Ryan White Programs Standards of Care

March 2015 (Appendices updated October 2015)
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
HIV CARE SECTION

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INTRODUCTION

Michigan Department of Health and Human Services (MDHHS), HIV Care Section (HCS) is the Michigan grantee of the federal Ryan White Part B funds, issued by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). These funds aim to provide funding to people living with HIV (PLWH) "who have no health insurance (public or private), have insufficient health care coverage, or lack financial resources to get the care they need for their HIV disease." (hab.hrsa.gov). In addition, MDHHS/HCS is a grantee of the Ryan White Part D funds, also issued by HRSA/HAB. Part D focuses funding on outpatient or ambulatory family-centered primary medical care and support services for women, infant, children, and youth with HIV. All Ryan White funding supports services that fill gaps left by other funding sources and addresses the social determinants of health that contribute to HIV-related health disparities.

MDHHS/HCS activities are aligned with the National HIV/AIDS Strategy (NHAS) developed by the White House Office of National AIDS Policy in 2010 (see NHAS). In accordance with NHAS goals and HRSA/HAB guidelines, MDHHS/HCS programs aim to:
Identify and link to medical care people who were previously unaware of their HIV status
Reengage PLWH who are lost to medical care
Support PLWH in maintaining ongoing HIV medical care
Provide resources to address social determinants and reduce HIV-related health disparities
Assist PLWH to achieve positive health outcomes, including HIV viral load suppression

To accomplish these goals, MDHHS/HCS funds Ryan White core medical and support services. Seventy-five percent of Ryan White funds are utilized for core medical service categories, which include services that directly focus on medical or clinical activities. On the other hand, twenty-five percent of Ryan White funds are used for support service categories, which provide wrap-around services that address psychosocial barriers to medical care adherence.

This document outlines the Ryan White Standards of Care for all MDHHS/HCS-funded programs. The purpose of these standards is to ensure the quality and consistency of MDHHS-funded Ryan White core medical and support service categories throughout the state. These standards were developed in collaboration with Ryan White service providers, Detroit Department of Health and Wellness Promotion (Ryan White Part A Grantee), and Southeastern Michigan HIV/AIDS Council (SEMHAC).

In reviewing the items within this document, it is important to keep the following in mind:

- In addition to being adherent to these Standards of Care, it is also important to adhere to the HRSA/HAB National Monitoring Standards--Universal and HRSA/HAB National Monitoring Standards--Part B. HRSA/HAB standards take precedence over MDHHS/HCS Standards of Care.
- Items in the Universal Standards apply to all service categories.
- Additional program information related to a service category is provided in the Appendix. These items are subject to change based on grant and contract requirements.
- Throughout the document, the term consumer refers to individuals being served by a Ryan White program and this term is used interchangeably with client or patient.

- This is a living document and may change based on HRSA/HAB requirements, the needs of PLWH in Michigan, and the services offered by providers. MDHHS/HCS will actively work to keep this document updated. To offer comments regarding this document or considerations for future revisions, please contact MDHHS/HCS at 517-241-5900.

UNIVERSAL STANDARDS

IMPORTANT: Prior to reading these standards, please read the HRSA/HAB National Monitoring Standards--Universal.

STANDARD	MEASURE
1. Access to Services	
a. Services must be provided irrespective of age, physical or mental challenges, creed, criminal history, history of substance use, immigration status, marital status, national origin, race, sexual orientation, gender identity and expression, socioeconomic status, or current/past health conditions.	• Policies and procedures • Consumer grievances
b. Providers must make translator or interpreter services available for those consumers who need them.	• Policies and procedures • Program literature in applicable language
c. Services must be provided in accordance with the Americans with Disability Act guidelines. For more information, refer to: ADA Guidelines.	• Policies and procedures
d. Providers must have written instructions for consumers on how to access the provider after business hours.	• Policies and procedures • Informational flyers, handouts
2. HIV Continuum of Care	
a. Providers must establish formal collaborative agreements with HIV and other service organizations.	• Memoranda of Agreement or Memoranda of Understanding
b. Providers must inform consumers of the various HIV services and resources available throughout the state.	• Informational flyers, handouts, resource manuals, literature • Documentation in consumer records of resources given
c. Providers must have a resource referral and tracking system with identified HIV and other service providers.	• Referral tracking system for each service category
3. Staff Requirements	
a. Providers must have written personnel policies and procedures.	• Policies and procedures
b. Providers must offer to staff and contracted service providers their job descriptions that address minimum qualifications, core competencies, and job responsibilities.	• Position descriptions
c. Providers must ensure that services are provided in a culturally-competent, compassionate, non-judgmental, and comprehensible manner.	• Training/in-service certificates/sign-in sheets • Staff interview • Consumer satisfaction survey • Consumer grievances

STANDARD	MEASURE
d. Providers must ensure that staff and contracted service providers delivering direct services to consumers must have knowledge of the: • HIV/AIDS disease process • Effects of HIV/AIDS-related illnesses and co-morbidities on consumers • Psychosocial effects of HIV/AIDS on consumers and their families/significant others • Current strategies for the management of HIV/AIDS • HIV-related resources and services in Michigan For more information, refer to: DHHS Guidelines.	• Documentation of this knowledge via formal education, trainings, or other methods. Types of documentation may include, but is not limited to, medical degree, license/certification, training certificates, transcripts. • Staff interview
e. Providers must ensure that professional staff and contracted service providers follow, at minimum, established codes of conduct for their discipline. For paraprofessional staff, providers must ensure that an agency code of conduct is established and that staff follow the code.	• Codes of Conduct • Trainings/in-service certificates/sign-in-sheets • Staff interview
f. Providers must ensure that staff and contracted service providers receive ongoing supervision that is relevant and appropriate to their professional needs.	• Supervisory/case conference meeting logs • Documentation of supervisory consumer record reviews
g. Providers must ensure that staff and contracted service providers conduct business in a manner that ensures the confidentiality of consumers and follows established protocols outlined in the Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Public Health Code.	• Policies and procedures • Trainings/in-service certificates/sign-in sheets • Staff signatures on agency's Confidentiality/HIPAA statements • Staff interview
4. Safety and Emergency Procedures	
a. Providers must ensure that services are provided in facilities that are clean, comfortable, and free from hazards.	• Site visit observation
b. Providers must have policies and procedures for the following: • Physical Plant Safety • Emergency Procedures that include fire, severe weather, and intruder/weapon threat • Medical/Health Care Crisis • Infection Control and Transmission Risk • Crisis Management	• Policies and procedures • Site visit observation • Training certificates and/or sign-in sheets • Staff interview

STANDARD	MEASURE
• Risk Assessment • Accident / Incident Reporting Provider must ensure that staff and contracted service providers are trained and following the safety and emergency procedures.	
c. Providers must follow recommended Occupational Safety and Health Administration (OSHA) and Michigan Occupational Safety and Health Administration (MIOSHA) regulations.	• Policies and procedures • Site visit observation • Training certificates and/or sign-in sheets • Staff interview
d. Providers must follow the Association for Professional in Infection and Epidemiology Guidelines (APIC) and/or Society for HealthCare Epidemiology of America (SHEA) guidelines in caring for immune-compromised individuals.	• Policies and procedures • Site visit observation • Training certificates and/or sign-in sheets • Staff interview
5. Consumer Eligibility and Recertification Requirements	
a. Providers must ensure that Ryan White funds are used as a payer of last resort.	• Policies and procedures • Documentation in consumer records of accessing resources from other payers
b. Providers must verify proof of HIV status, income, residency, and insurance in accordance with the MDHHS Ryan White Program Guidance #14-01.	• Policies and procedures • Documentation in consumer records of established eligibility and recertification within specified timeframes
c. Proof of HIV status must be established within 30 business days of intake.	• Policies and procedures • Documentation in consumer records of established HIV status within specified timeframe
d. If a consumer is not enrolled in an insurance plan, providers must assist the consumer with benefits counseling and enrollment into an appropriate insurance plan.	• Policies and procedures • Documentation in consumer records of benefits counseling/enrollment
6. Intake	
a. Providers must screen consumers into appropriate Ryan White service categories as determined by presenting needs.	• Documentation in consumer records of screening for appropriate Ryan White services
b. Providers must complete an intake with consumers within 5 business days of initial contact.	• Documentation in consumer records of timely intake within specified timeframes

STANDARD	MEASURE
c. The intake form must include, at minimum, all the required data elements included in the most recent RSR Manual. The most recent version of this manual can be found at the HRSA/HAB Target Center.	• Intake form, with all the required data elements • Documentation in consumer records of completed intakes
7. Consents and Related Consumer Documentation	
a. Providers must obtain and document consumer's informed consent for provision of Ryan White services.	• Consent to Serve form
b. Providers must ensure that consumer records are maintained in a secure location.	• Policies and procedures • Staff interview • Site visit observation
c. Providers must have policies and procedures to ensure that consumers' medical records and other personal health information are: • Securely faxed, emailed, or phoned • Safely transported during the course of conducting business • Securely stored electronically with limited access • Shared with third parties in accordance with HIPAA	• Policies and procedures • Staff interview • Site visit observation
d. Providers must have a written statement outlining consumer rights that, at minimum, includes: • Nature of services offered. • Conditions for service • The ability to terminate service at any time. • Transfer and discharge procedures • Consumer progress review • Access to consumer records	• Consumer Rights and Responsibilities form
e. Providers must have a written statement outlining consumer responsibilities that, at minimum, includes: • Scheduling, rescheduling, and cancelling appointments • Drug and alcohol use on premises • Weapons on premises • Acts of abuse towards staff, property or services	• Consumer Rights and Responsibilities form
f. Providers must have an objective process to address and track consumers' grievances.	• Policies and procedures • Documentation of resolution of grievance

STANDARD	MEASURE
g. Providers must have releases of information that, at minimum, includes information regarding: • To what/whom information will be released, including name of organization or person (emergency contact), address, etc. • What specific information will be released • Time-limits for releases to not exceed 1 year • Printed name and signature of consumer/legal guardian • Signature of a witness Releases of information are not valid once a consumer is discharged from services.	• Release of Information form • Documentation in consumer records of signed and updated releases of information before third party disclosures are made
h. Within 30 business days of completing intake, providers must review with consumer and obtain signed documentation of the following consents and related documentation: • Consent to Serve form • Confidentiality Procedures, including HIPAA • Consumer Rights and Responsibility • Grievance process	• Documentation in consumer records of signed documentation
8. Discharge	
a. A discharge from services must occur if any of the following criteria is met: • Completion of services • Consumer's death • Verification of HIV positive status cannot be obtained within 30 business days of intake • Verification of eligibility cannot be obtained • The consumer/legal guardian has requested the case be closed • Relocation of consumer outside of the provider's geographic service area • Inability to contact the consumer for more than 90 calendar days • The consumer's needs are more appropriately addressed through other providers • The consumer exhibits acts of abuse towards staff, property or services	• Documentation in consumer records that discharge criteria was followed
b. Providers must notify consumers when they are being discharged.	• Documentation in consumer records of consumers being notified of discharge

STANDARD	MEASURE
9. Consumer Satisfaction	
a. Providers must establish evaluation methods to assess consumer satisfaction and receive feedback on services using any of the following methods: • Consumer Advisory Board • Consumer satisfaction survey • Suggestion box or other consumer input mechanism • Focus groups and/or public meetings	• Consumer Advisory Board meeting notes/minutes • Consumer satisfaction survey/results • Visual verification of suggestion box or other consumer input mechanisms during site visit • Notes or reports from focus groups and/or public meetings
b. Providers must use results from evaluation methods to improve service delivery.	• Quality Improvement Plan • Modification to service delivery policies and procedures based on feedback • Inclusion of consumer feedback in internal training/staff communications

OUTPATIENT AND AMBULATORY MEDICAL CARE

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Provision of Outpatient and Ambulatory Medical Care, defined as the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with Public Health Services (PHS) guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Allowable services include: diagnostic testing; early intervention and risk assessment; preventive care and screening; practitioner examination; medical history taking; diagnosis and treatment of common physical and mental conditions; prescribing and managing of medication therapy; education and counseling on health issues; well-baby care; continuing care and management of chronic conditions; referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services).

As part of outpatient and ambulatory medical care, provision of laboratory tests integral to the treatment of HIV infections and related complications."

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Staff Requirements	
a. Primary health care clinics must be licensed and, where applicable, accredited to deliver primary medical care.	• A copy of most recent license
b. Ryan White clinic staff and contracted service providers must have current license and/or certification within their professional scope of practice and as required by the State of Michigan.	• A copy of most recent license
2. Service Delivery	
a. Core elements of HIV primary care must include: • A complete history and physical exam • Laboratory tests, including drug resistance testing • Antiretroviral therapy	• Documentation in consumer records of specified core elements

• Age-appropriate immunizations • Prescriptions for prophylaxis and/or treatment of opportunistic infections • Medication adherence counseling • For females, completions of regular gynecological exams and appropriate follow-ups • Screening and referrals for sexually transmitted diseases • Screening for Latent Tuberculosis Infections (LTBI) performed and results interpreted at least once since the HIV diagnosis • Screening and referral for other acute and/or chronic medical comorbidities, including Hepatitis • Screening and referral for mental health/substance abuse treatment and medical case management • Assessment of high risk behaviors and referrals to provide HIV prevention education • Screenings for clinical trials, as appropriate For more information, refer to: DHHS Guidelines.	
b. The medical care provider must work in partnership with their consumer to offer adequate information about their health and consumer-centered treatment options.	• Documentation in consumer records of instructions and education regarding treatment options • Documentation in consumer records of interventions to assist consumer adherence to a plan of care

EARLY INTERVENTION SERVICES

This service category only applies to Ryan White Part B-funded programs.

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition

Support of Early Intervention Services that include identification of individuals at points of entry and access to services and provision of: HIV testing and targeted counseling, referral services, linkage to care, and health education and literacy training that enable clients to navigate the HIV system of care. All four components to be present, but Part A/B funds to be used for HIV testing only as necessary to supplement, not supplant, existing funding" (2013 HRSA/HAB National Monitoring Standards—Part B).

CAREWare Data Definitions

Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Assessment of needs	
a. During initial contact with consumer, the early intervention services (EIS) provider must assess: • Barriers to medical care • Psychosocial needs • Health education, risk reduction, and health literacy needs	• Documentation in consumer records of the assessment of identified areas
b. All EIS providers must complete HIV Test Counselor Certification provided by MDHHS.	• Training certificates/records for appropriate EIS staff
2. Linkage to medical and psychosocial resources	
a. The EIS provider must link consumers to, at minimum, two HIV medical care visits.	• Documentation in consumer records of verification of HIV medical care visits. Acceptable methods of verification include: 1. EIS provider physically attended appointment with consumer and/or 2. EIS provider confirmed appointment attendance with medical provider.

STANDARD	MEASURE
b. The EIS provider must link consumers to health insurance, medication access, and/or AIDS Drug Assistance Program (ADAP) resources.	• Documentation in consumer records of being successfully linked to appropriate insurance/medication access resources
c. The EIS provider must link consumers to psychosocial resources that address barriers to establishing medical care.	• Documentation in consumer records of being successfully linked to appropriate psychosocial resources
3. Health education, risk reduction, and health literacy	
a. The EIS provider must offer ongoing education to consumers on the identified health education, risk reduction, and health literacy needs. At minimum, the provider must ensure that consumers have knowledge of: • HIV 101 (including CD4 and viral load count), • Insurance and health system navigation • Medical care and medication adherence.	• Documentation in consumer records of education sessions that include, at minimum, the identified topics
4. Documentation	
a. The EIS provider must document any and all efforts to work with consumer and provide services, such that progress notes and units of services match in CAREWare.	• Documentation in consumer records of progress notes that correspond to the units of service
5. Discharge	
a. The EIS provider may work with consumers for a maximum of 6 months to facilitate linkage to care. This timeframe may be extended with supervisor approval.	• Documentation in consumer records of timely discharge • If consumer needs EIS services beyond 6 months, Documentation in consumer records of supervisory consultation and approval
b. The EIS provider must ensure a consumer-centered discharge plan that includes connection to other resources along the HIV continuum of care.	• Documentation in consumer records of discharge plan

HEALTH INSURANCE PREMIUM AND COST-SHARING ASSISTANCE

This service category only applies to Ryan White Part B-funded programs.

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Provision of Health Insurance Premium and Cost-sharing Assistance that provides a cost-effective alternative to ADAP by: purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low income clients that provide a full range of HIV medications; paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of the client; providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs." (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

PLEASE SEE HRSA STANDARD as well as the following links provided by HRSA *(links provide clarity on how to use Ryan White funding for Health Insurance Premium and Cost-Sharing Assistance)*

- HRSA Policy Clarification Notice #13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-sharing Assistance for Private Health Insurance: http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf

- HRSA Policy Clarification Notice #13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-sharing Assistance for Medicaid http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1306medicaidpremiumcostsharing.pdf

HOME AND COMMUNITY-BASED HEALTH SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Provision of Home and Community-based Health Services, defined as skilled health services furnished in the home of an HIV-infected individual, based on a written plan of care prepared by a case management team that includes appropriate health care professionals. Allowable services to include: durable medical equipment; home health aide and personal care services; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostic testing; appropriate mental health, developmental, and rehabilitation services; specialty care and vaccinations for hepatitis con-infection, provided by public and private entities.(2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Staff Requirements	
a. Home and Community-based Health care providers must meet the minimum licensing/credentialing requirements of the State of Michigan for the home healthcare service(s) that they are providing.	• A copy of the current credential
2. Service Delivery	
a. Core elements of Home and Community-based Health Services must include: • Physician order; • Home visit with a nursing assessment; • Development of a written care plan, signed by physician; and • Appropriate referrals to meet needs identified in nursing assessment.	• Evidence in consumer records of physician order, home visit and nursing assessment, signed care plan, and referrals
3. Reauthorization	
a. Services must be reauthorized per the following: • Nursing, speech, physical, and occupational therapy services must be reauthorized by a physician every 60 days. • All other services (e.g., home health aide) must	• Evidence in consumer records of reauthorization

STANDARD	MEASURE
be reauthorized every 120 days. • Reauthorization decisions must be made in conjunction with the nurse, physician, and other staff (e.g., medical case manager) as appropriate.	
4. Service Coordination	
a. Services must be coordinated with consumer's medical care and support services, including medical case management.	• Evidence in consumer records of coordination with other service providers
5. Documentation	
a. The provider must document all services provided to consumer, such that notes and units of services match in CAREWare.	• Evidence in consumer records of notes that correspond to the units of service
6. Discharge	
a. The provider must complete a discharge summary that indicates services have been completed and consumer progress.	• Evidence in consumer records of completed discharge summary

MENTAL HEALTH SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Funding for Mental Health Services that include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services typically including psychiatrists, psychologists, and licensed clinical social workers. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Staff Requirements	
a. Providers must ensure that staff and contracted service providers are mental health professionals currently licensed to provide such services.	• A copy of most recent license
2. Assessment	
a. A face-to-face assessment must be completed within 30 business days of intake at a location that is mutually acceptable to the consumer and mental health treatment provider.	• Documentation in consumer records of completed assessment form or progress note within specified timeframe
b. The assessment must include, at minimum, a review of the following areas: • Presenting problems • Medical history and medications • Mental health and psychiatric history • Substance use and treatment history • Family history • History of trauma • Psychological functioning • Leisure and recreational activities • Social support	• Assessment form or progress note

STANDARD	MEASURE
c. A psychiatric evaluation, as needed, must be completed within 30 business days of the assessment.	• Documentation in consumer records of a completed psychiatric evaluation
3. Treatment Plan	
a. A treatment plan is developed collaboratively with the consumer within 30 business days of intake.	• Documentation in consumer records of completed treatment plan within specified timeframe
b. The treatment plan must include: • Clinical mental health diagnosis • A description of the need(s) • Action steps/interventions to address the need(s) • The treatment modality • Timeframes to address the need(s), including recommended number of sessions • Dated signatures of the consumer and mental health treatment provider	• Completed and signed Treatment Plan form
c. The mental health supervisor must review and sign the treatment plans.	• Documentation in consumer records of treatment plan with relevant signatures
4. Continuity of Care	
a. The mental health treatment provider must assess on an ongoing basis the need for other mental health programs that may better meet consumer's clinical needs and provide appropriate referrals. These referrals may include day programs, inpatient psychiatric units, community mental health programs, etc.	• Documentation in consumer records of ongoing assessment of needs and appropriate referrals
b. The mental health treatment provider must maintain ongoing contact and follow-up with consumer's medical case manager, medical provider, and/or other psychosocial providers.	• Documentation in consumer records of ongoing contact with other service providers
c. The mental health treatment provider must review and update the treatment plan on an as needed basis.	• Documentation in consumer service plans that needs are closed out when they are met/deferred
5. Reassessment	
a. The mental health treatment provider must complete a reassessment, at minimum, every six months.	• Documentation in consumer records of a reassessment at specified timeframes

STANDARD	MEASURE
6. Discharge	
a. The mental health treatment provider must consult with supervisor to decide that a consumer is to be discharged.	• Documentation in consumer records of supervisory consultation
b. After a decision has been made to discharge consumer, the mental health treatment provider must complete a discharge summary within 10 business days.	• Documentation in consumer records of discharge summary within specified timeframes
c. The mental health treatment provider must ensure that the discharge summary includes: • Summary of needs at admission • Summary of services provided • Goals completed during treatment • Reason for discharge • Consumer-centered discharge plan • Referrals provided • Dated signatures of the mental health treatment provider	• Completed and signed Discharge Summary form
d. The mental health supervisor must review and sign the discharge summary.	• Documentation in consumer records of discharge summary with relevant signatures

MEDICAL NUTRITION THERAPY

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Support for Medical Nutrition Therapy services including nutritional supplements provided outside of a primary care visit by a licensed registered dietitian; may include food provided pursuant to a physician's recommendation and based on nutritional plan developed by a licensed registered dietitian. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Staff Requirements	
a. The medical nutrition therapy provider must be currently registered dietitians (RD) that have a Master's degree in a nutrition-related major.	• Documentation of dietitian registration status
b. The RD must maintain membership in the Academy of Nutrition and Dietetics and a course of professional experience that includes at least 900 hours of supervised experience in the practice of nutrition.	• Documentation of membership • Documentation of work experience
2. Service Delivery	
a. The RD must ensure that consumers receive the following services: • Nutritional evaluation/assessment • Nutrition care plan developed based on the nutritional evaluation/assessment • Nutrition counseling and therapy • Provision of nutritional supplements, as appropriate • HIV and nutrition trainings, educational materials, etc.	• Documentation in consumer records of outlined service components
b. The RD must develop a consumer-centered nutritional care plan that contains medically and culturally relevant recommendations.	• Documentation in consumer records of completed nutritional care plans that address needs identified in evaluation/assessment and

	take into account consumer's unique needs
c. The RD must maintain ongoing contact and coordinate services with consumer's medical provider.	• Documentation in consumer records of ongoing contact with medical provider

MEDICAL CASE MANAGEMENT (including TREATMENT ADHERENCE)

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Support of Medical Case Management (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication. Activities that include at least the following: initial assessment of service needs; development of a comprehensive, individualized care plan; coordination of services required to implement the plan; continuous client monitoring to assess the efficacy of the plan; periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary.

Service components that may include: a range of client-centered services that link clients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services); coordination and follow-up of medical treatments; ongoing assessment of the client's and other key family members' needs and personal support systems; treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments; client-specific advocacy and/or review of utilization of services." (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Staff Requirements	
a. The minimum education requirements for medical case managers is a Registered Nurse (RN), Bachelor of Social Work (BSW), or other related health or human service degree from an accredited college or university. Medical case managers who were hired prior to	• A copy of the diploma/credentials • If medical case manager is hired prior to 2015 and does not meet the minimum education requirements, Documentation of 2 years of

STANDARD	MEASURE
2015 may substitute related direct consumer service experience under the supervision of a human services professional for a period of 2 years of full time work regardless of academic preparation.	related direct consumer service experience under supervision
b. The minimum education requirements for medical case management supervisors is a Registered Nurse (RN), Bachelor of Social Work (BSW), or other related health or human service degree from an accredited college or university. Medical case management supervisors who were hired prior to 2015 may substitute related direct consumer service experience under the supervision of a human services professional for a period of 5 years of full time work regardless of academic preparation.	• A copy of the diploma/credentials • If medical case management supervisor is hired prior to 2015 and does not meet the minimum education requirements, Documentation of 5 years of related direct consumer service experience under supervision
c. All medical case managers must have completed the training for medical case managers offered by MDHHS within 1 year of hire.	• Training certificates/records for appropriate staff
d. Direct supervisors of medical case managers must obtain the training for medical case managers offered by MDHHS within 1 year of hire	• Training certificates/records for appropriate staff
2. Assessment	
a. A face-to-face biopsychosocial assessment must be completed within 30 business days of intake at a location that is mutually acceptable to the consumer and medical case manager.	• Documentation in consumer records of completed assessment form or progress note within specified timeframe
b. The biopsychosocial assessment must include, at minimum, a review of the following areas: • Basic needs • Medical insurance and ADAP needs • Medical and Psychosocial History • Current medical care and medications • Medication readiness and treatment adherence counseling needs • Need for prevention counseling • Need for disclosure and/or Partner Services • Michigan law regarding informing sex and needle- sharing partner of HIV status	• Biopsychosocial assessment form

STANDARD	MEASURE
3. Acuity Screening	
a. An acuity screening is completed, at minimum, after an assessment or reassessment.	• Documentation in consumer records of completed acuity scale after each assessment/reassessment
b. The acuity screening must clearly indicate a consumer's appropriateness for medical case management services, as documented by the strengths, needs, and level of severity from the assessment or reassessment.	• Documentation in consumer records that strengths, needs, and level of severity assessed matches what is indicated in the acuity • Acuity scale indicates that consumer is appropriate for medical case management
4. Service Plan	
a. A service plan is developed collaboratively with the consumer within 30 business days of intake.	• Documentation in consumer records of completed service plan within specified timeframe
b. The service plan must include: • A description of the need(s) • Action steps to resolve the need(s) • Timeframes to resolve the need(s) • Documentation of who will complete action steps • Dated signatures of the consumer and medical case manager	• Completed and signed Service Plan form
c. The case management supervisor must review and sign the service plans.	• Documentation in consumer records of service plan with relevant signatures
5. Service Plan Monitoring	
a. The medical case manager must maintain ongoing contact and follow-up with consumers based on acuity level and service plan needs.	• Documentation in consumer records of service plan monitoring
b. The medical case manager must address consumers' barriers to access necessary resources and achieving service plan goals on an ongoing basis.	• Documentation in consumer records of identifying and addressing barriers
c. The medical case manager must maintain regular contact and follow-up with consumers' medical and other psychosocial providers.	• Documentation in consumer records of ongoing contact with other service providers
d. The medical case manager must provide ongoing education to consumers on identified treatment adherence needs. At minimum, the medical case manager must address:	• Documentation in consumer records of education sessions that include, at minimum, the identified topics

STANDARD	MEASURE
• HIV 101 (including CD4 and viral load) • Insurance and health system navigation • Medical care and treatment adherence (including readiness to HIV medications)	
e. The medical case manager must review and update the service plan on an as needed basis. At minimum, a new, updated service plan is completed at reassessment(s).	• Documentation on consumer service plans that needs are closed out when they are met/deferred • Documentation in consumer records of a new service plan after each reassessment
6. Reassessment	
a. The medical case manager must complete a reassessment every six months.	• Documentation in consumer records of a reassessment at specified timeframes
7. Documentation	
a. The medical case manager must document any and all efforts to work with consumer and provide services, such that progress notes and units of services match in CAREWare.	• Documentation in consumer records of progress notes that correspond to the units of service
8. Discharge	
a. The medical case manager must consult with supervisor to decide when a consumer is to be discharged.	• Documentation in consumer records of supervisory consultation
b. After a decision has been made to discharge consumer, the medical case manager must complete a discharge summary within 10 business days.	• Documentation in consumer records of discharge summary within specified timeframes
c. The medical case manager must ensure a discharge summary that includes: • Reason for discharge • Consumer-centered discharge plan • Referrals provided • Dated signature of the medical case manager	• Completed and signed Discharge Summary form
d. The medical case management supervisor must review and sign the discharge summary.	• Documentation in consumer records of discharge summary with relevant signatures

NON-MEDICAL CASE MANAGEMENT

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Support for Case Management (Non-medical) services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services. May include: benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible; all types of case management encounters and communications (face-to-face, telephone contact, other); transitional case management for incarcerated persons as they prepare to exit the correctional system. Does not involve coordination and follow-up of medical treatments. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Staff Requirements	
a. The minimum education requirement for non-medical case managers is a high school diploma or GED.	• A copy of the diploma/credentials
b. The minimum education requirements for non-medical case management supervisors is a Registered Nurse (RN), Bachelor of Social Work (BSW), or other related health or human service degree from an accredited college or university. Medical case management supervisors who were hired prior to 2015 may substitute related direct consumer service experience under the supervision of a human services professional for a period of 5 years of full time work regardless of academic preparation.	• A copy of the diploma/credentials • If medical case management supervisor is hired prior to 2015 and does not meet the minimum education requirements, Documentation of 5 years of related direct consumer service experience under supervision
c. Direct supervisors of non-medical case managers must obtain the training for medical case managers offered by MDHHS within 1 year of hire	• Training certificates/records for appropriate staff

STANDARD	MEASURE
2. Assessment of Needs	
a. Initial problems or needs are identified and prioritized by the consumer and the non-medical case manager.	• Documentation in consumer records of the assessment of needs
3. Action Plan and Follow-up	
a. An action plan that addresses the identified need(s) and provides referrals/resources is developed collaboratively with the consumer.	• Documentation in consumer records of completed action plan
b. The non-medical case manager must address consumers' barriers to access necessary resources on an ongoing basis.	• Documentation in consumer records of identifying and addressing barriers
c. The non-medical case manager must conduct follow-up to referrals/resources within 30 business days of creating the action plan.	• Documentation in consumer records of following-up on referrals/resources within specified timeframe
d. The non-medical case manager must assist the consumer until their initial needs have been addressed.	• Documentation in consumer records of assisting with initial needs
e. If additional problems or needs develop, it is the responsibility of the consumer to notify the non-medical case manager.	• Documentation in consumer records of assisting with additional needs
4. Documentation	
a. The non-medical case manager must document any and all efforts to work with consumer and provide services, such that progress notes and units of services match in CAREWare.	• Documentation in consumer records of progress notes that correspond to the units of service

EMERGENCY FINANCIAL ASSISTANCE

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Support for Emergency Financial Assistance for essential services including utilities, housing, and food (including groceries, food vouchers, and food stamps), or medications, provided to clients with limited frequency and for limited periods of time, through either: short-term payments to agencies or establishment of voucher programs. Direct cash payments to clients are not permitted." (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Eligibility Criteria	
a. Providers must have established eligibility criteria for the provision of emergency financial assistance that includes, at minimum: • Income limits • Amount limits • Requirements to access other resources before Ryan White funds • Documentation of need and why it is an emergency • Documentation verifying that consumer is in HIV medical care	• Eligibility criteria • Documentation in consumer records of consumer meeting eligibility criteria
b. Emergency financial assistance for housing and/or utilities may not be provided to a consumer more than once per contract year.	• Policies and procedures • Documentation in consumer records of emergency financial assistance limits
2. Service Delivery	
a. Providers must have established policies and procedures for service delivery.	• Policies and procedures
3. Continuity of Care	
a. Providers must ensure that consumers are in care or actively taking steps to engage in HIV medical care. If consumers need assistance accessing HIV medical care, referrals must be provided.	• Documentation in consumer records of being in HIV medical care

FOOD BANK/HOME-DELIVERED MEALS

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Funding for Food Bank/Home-delivered Meals that may include: the provision of actual food items; provision of hot meals; a voucher program to purchase food. May also include the provision of non-food items that are limited to: personal hygiene products; household cleaning supplies; water filtration/purification systems in communities where issues with water purity exist. Appropriate licensure/certification for food banks and home delivered meals where required under State or local regulations. No funds used for: permanent water filtration systems for water entering the house; household appliances; pet foods; other non-essential products. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Eligibility Criteria	
a. Providers must have established eligibility criteria for the provision of food bank/home-delivered meals that includes, at minimum: • Income limits • Department of Human Services Food Assistance Program (FAP) limits • Family size limits	• Eligibility criteria • Documentation in consumer records of consumer meeting eligibility criteria
2. Licensing and Regulations	
a. Providers must maintain all licenses and permits required by law to operate the particular food service programs.	• Copy of current license on display at site
3. Service Delivery	
a. Providers must have established policies and procedures for service delivery.	• Policies and procedures

HOUSING SERVICES

This service category only applies to Ryan White Part B-funded programs.

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition

Support for Housing Services that involve the provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Funds received under the Ryan White HIV/AIDS Program may be used for the following housing expenditures: housing referral services defined as assessment, search, placement, and advocacy services must be provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how these programs can be accessed; or short-term or emergency housing defined as necessary to gain or maintain access to medical care and must be related to either: housing services that include some type of medical or supportive service including, but not limited to residential substance treatment or mental health services (not including facilities classified as an Institution for Mental Diseases under Medicaid), residential foster care, and assisted living residential services; or housing services that do not provide direct medical or supportive services, but are essential for an individual or family to gain or maintain. Access and compliance with HIV-related medical care and treatment; necessity of housing services for purposes of medical care must be certified or documented.

Grantees must develop mechanisms to allow newly identified clients access to housing services. Upon request, Ryan white HIV/AIDS Program Grantees must provide HAB with an individualized written housing plan, consistent with this Housing Policy, covering each clients receiving short term, transitional and emergency housing services. Short-term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term stable living situation. Housing funds cannot be in the form of direct cash payments to recipients or services and cannot be used for mortgage payments. Ryan White HIV/AIDS Program Grantees and local decision making planning bodies, i.e. Part A and Part B, are strongly encouraged to institute duration limits to provide transitional and emergency housing services. HUD defines transitional housing as 24 months and HRSA/HAB recommends that grantees consider using HUD's definition as their standard." (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions

Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Service Eligibility Criteria	
a. The agency has policies and procedures regarding housing that defines: • the use of funds, including time limits, the maximum amount per contract year, and re-application periods • that Ryan White funds will not pay more than the Fair Market Rent (FMR) in assistance • emergency housing, including what documentation is necessary for validating the conditions • the use of funds for short term lodging and that Ryan White funds will NOT cover all incidental charges such as food and beverages, telephone, liquor, tobacco products, movies and entertainment. • that transitional housing is limited to twenty-four (24) months; with supervisor approval this may be extended • that funds paid for housing are substantially different from Emergency Financial Assistance in that housing funds should be used to secure long-term, stable funding for persons living with HIV	• Policies and procedures • Documentation in consumer records of following established policies and procedures
2. Service Delivery	
a. A consumer assessment must be completed and will include an evaluation of the consumer's housing needs, strengths, resources, limitations, and projected barriers to service.	• Documentation in consumer records of a housing assessment
b. Housing payments are made out to a vendor and authorized for pick up by the consumer. No payment may be made directly to consumers, family, or household members.	• Copy of invoice/bill paid • Copy of check for payment • Copy of documentation of application for other assistance, if applicable • Letter documenting need and attempts at locating other available resources

LEGAL SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Funding for Legal Services provided for an HIV-infected person to address legal matters directly necessitated by the individual's HIV status. May include such services as (but not limited to): preparation of powers of attorney and living wills, interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under Ryan White. Permanency planning and for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS; includes the provision of social service counseling or legal counsel regarding (1) the drafting of wills or delegating powers of attorney, (2) preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption. Excludes: criminal defense, class-action suits unless related to access to services eligible for funding under the Ryan White HIV/AIDS Program." (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Staff Requirements	
a. Providers must ensure that attorneys are members of the Michigan Bar Association.	• Copy of a current Bar Card in staff file
2. Consumer and family participation	
a. Consumers are kept informed and work together with staff and contracted service providers to decide the objective of the representation, to make decisions regarding the case, and to achieve goals in a timely fashion.	• Copy of retainer agreement between consumer and agency is in consumer file • Data from file shows consumer is kept informed and is involved in making decisions about the case and that goals are completed in a timely fashion
3. Supervision	
a. Legal service providers hold regular case acceptance and case review meetings	• Copy of case acceptance and case review minutes on file

MEDICAL TRANSPORTATION

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Funding for Medical Transportation Services that enable an eligible individual to access HIV-related health and support services, including services needed to maintain the client in HIV medical care, through either direct transportation services or vouchers or tokens. May be provided through: contracts with providers of transportation services voucher or token systems, use of volunteer drivers (through programs with insurance and other liability issues specifically addressed), purchase, or lease of organizational vehicles for client transportation programs, provided the grantee receives prior approval for the purchase of a vehicle." (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Eligibility Criteria	
a. The provider must screen for medical transportation eligibility by assessing level of need and determining if consumer has other means of transportation (i.e. Medicaid HMO). Based on screening, the provider can determine what type of medical transportation is appropriate (i.e. bus tickets/card, cab/van, voucher, etc.)	• Policies and procedures • Screening tools/process • Documentation in consumer records of screening
b. Bus tickets/cards must be used by consumer to access HIV-related health and support services, which includes getting to and from appointments for: • Medical care • Mental health treatment • Substance abuse treatment • Dental care • Vision care • Department of Human Services • Social Security Administration	• Documentation in consumer records that the provision of bus tickets met established criteria

STANDARD	MEASURE
c. The provider must make appropriate referrals to other transportation resources if consumers do not meet the criteria for medical transportation.	• Documentation in consumer records of referrals
2. Service Delivery (for direct transportation providers)	
a. Drivers must have, at minimum, a valid chauffer's license. The provider must verify the driving records of all drivers once a year.	• Copy of current Chauffeur's License • Documentation of annual review of records
b. All vehicles used in medical transportation must have appropriate, updated registration and insurances.	• Copy of vehicle registration and insurance
c. All vehicles used in medical transportation must have regular maintenance and inspections according to the vehicle's maintenance schedule.	• Policies and procedures for routine service and inspection • Documentation of vehicle maintenance history
d. All vehicles used in medical transportation must have standard safety equipment in compliance with federal and state laws.	• Policies and procedures on driver and passenger safety
e. The provider must ensure that medical transportation services are available to those with disabilities who may require assistive devices.	• Site visit observation that confirms presence of assistive equipment • Documentation that proper maintenance of transport mechanisms are available and documented
f. The provider must offer curb to curb transportation services to consumers with disabilities.	• Policies and procedures • Notification to consumer of limitation of drivers on file
g. The provider must ensure that medical transportation services are available for consumers with needs outside of normal business hours.	• Policies and procedures for accommodating consumers between 5 p.m. and 7 a.m.

PSYCHOSOCIAL SUPPORT

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition
Support for Psychosocial Support Services that may include: support and counseling activities; child abuse and neglect counseling; HIV support groups; pastoral care/counseling; caregiver support; bereavement counseling; nutrition counseling provided by a non-registered dietitian. Funds under this service category may not be used to provide nutritional supplements. Pastoral care/counseling supported under this service category to be: provided by an institutional pastoral care program (e.g. components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as home care or hospice provider); provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available; available to all individuals eligible to receive Ryan White services, regardless of their religious denominational affiliation." (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions
Refer to the most recent *MDCH Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures
Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
1. Service Delivery	
a. The provider must document services provided to the consumer.	• Sign-in sheets at support groups • Documentation in consumer records of individual counseling, if applicable
b. The provider must document topics or interventions that were implemented.	• List of group session topics • Documentation in consumer records of individual counseling session topics/interventions
c. On an annual basis, the provider must evaluate the services and topics covered to ensure they meet consumer needs.	• Consumer satisfaction survey • Modification to service delivery based on feedback • Inclusion of consumer feedback in staff training

SERVICE CATEGORIES WITHOUT MICHIGAN-SPECIFIC STANDARDS

The following service categories, listed with their HRSA/HAB service definitions, do not have Michigan-specific program standards at this time. However, these service categories still must follow the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

For more information on the CAREWare data definitions for the service categories below, refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* (Appendix A). For more information on the performance measures for the service categories below, refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

Core Medical Services

Home Health Care
Support for Home Health Care services provided in the patient's home by licensed health care workers such as nurses; services to exclude personal care and to include: the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Hospice Services
Provision of Hospice Care provided by licensed hospice care providers to clients in the terminal stages of illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients. Allowable services: room, board, nursing care, mental health counseling, physician services, palliative therapeutics.

Substance Abuse Treatment Services – Outpatient
Support for Substance Abuse Treatment Services-Outpatient, provided by or under the supervision of a physician or other qualified/licensed personnel; may include use of funds to expand HIV-specific capacity programs if timely access to treatment and counseling is not otherwise available. Services limited to the following: pre-treatment/recovery readiness programs; harm reduction; mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse; outpatient drug-free treatment and counseling; opiate assisted therapy; euro-psychiatric pharmaceuticals; relapse prevention; limited acupuncture services with a written referral from the client's primary health care provider, provided by certified or licensed practitioners wherever State certification or licensure exists; services provided must include a treatment plan that calls only for allowable activities and includes: the quantity, frequency, and modality of treatment provided; the date treatment begins and ends; regular monitoring and assessment of client progress; the signature of the individual providing the service and/or the supervisor as applicable.

Support Services

Child Care Services

Funding for Child Care Services for the children of HIV-positive clients, provided intermittently, only while the client attends medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions. May include use of funds to support: a licensed or registered child care provider to deliver intermittent care; informal childcare provided by a neighbor, family member, or other person (with the understanding that existing Federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services). Such allocations to be limited and carefully monitored to assure: compliance with the prohibition on direct payments to eligible individuals; assurance that liability issues for the funding source are carefully weighed and addressed through the use of liability release forms designed to protect the client, provider, and the Ryan White program. May include Recreational and Social Activities for the child, if provided in a licensed or certified provider setting including drop-in centers in primary care or satellite facilities. Excludes use of funds for off-premise social/recreational activities.

Health Education/Risk Reduction

Support for Health Education/Risk Reduction services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. Includes: provision of information about available medical and psychosocial support services; education on HIV transmission and how to reduce the risk of transmission; counseling on how to improve their health status and reduce the risk of HIV transmission to others.

Linguistic Services

Support for Linguistic Services including interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of Ryan White-eligible services.

Outreach

Support for Outreach Services designed to identify individuals who do not know their HIV status and/or individuals who know their status and are not in care and help them to learn their status and enter care. Outreach programs must be: planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; targeted to population known through local epidemiologic data to be at disproportionate risk for HIV infection; targeted to communities or local establishments that are frequented by individuals exhibiting high-risk behavior; conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; designed to provide quantified program reporting of activities and results to accommodate local evaluation of effectiveness. Funds may not be used to pay for HIV counseling and testing.

Pediatric Development Assessment/Early Intervention Services (Only Part D)

Professional early interventions by physicians, developmental psychologists, educators, and others for the psychosocial and intellectual development of infants and children. They involve the assessment of an infant or child's developmental status and needs in relation to the

education system, including early assessment of educational intervention services. They include comprehensive assessment, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-infected clients, and education/assistance to schools also should be reported in this category.

Permanency Planning (Only Part D)
Services to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them. It includes the provision of social service counseling or legal counsel regarding (1) drafting of wills or delegating powers of attorney; and (2) preparation for custody options for legal dependents, including standby guardianship, joint custody, or adoption.

Referral for Health Care/Supportive Services
Support for Referral for Health Care/Supportive Services that direct a client to a service in person or through telephone, written, or other types of communication, including the management of such services where they are not provided as a part of Ambulatory/Outpatient Medical Care or Case Management services. May include benefits/entitlement counseling and referral to refer to assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services. Referrals may be made: within the non-medical case management system by professional case managers; informally though community health workers or support staff; or as part of an outreach program.

Rehabilitation Services
Services intended to improve or maintain a client's quality of life and optimal capacity for self-care, provided by a licensed or authorized professional in an outpatient setting in accordance with an individualized plan of care. May include: physical and occupational therapy; speech pathology services; low-vision training.

Respite Care
Support for Respite Care that includes non-medical assistance for an HIV-infected client, provided in community or home-based settings and designed to relieve the primary caregiver responsible for the day-to-day care for an adult or minor living with HIV/AIDS. Note: Funds may be used to support informal respite care provided issues of liability are addressed; payment made is reimbursement for actual costs; and no cash payments are made to clients or primary care givers.

Substance Abuse Residential Services (Only Part B)
Funding for Substance Abuse Treatment-Residential to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a short-term residential health service setting. Requirements: services to be provided by or under the supervision of a physician or other qualified personnel with appropriate and valid licensure and certification by the State in which the services are provided; services to be provided in accordance with a treatment plan; detoxification to be provided in a separate licensed residential setting (including a separately-

licensed detoxification facility within the walls of a hospital); limited acupuncture services permitted with a written referral from the client's primary health care provider, provided by certified or licensed practitioners wherever State certification or licensure exists.

Treatment Adherence Counseling
Support for Treatment Adherence Counseling, which is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments, provided by non-medical personnel outside of the Medical Case Management and clinical setting.

APPENDIX A

Michigan Department of Health and Human Services
Ryan White Parts B and D
CAREWare Service Categories and Sub-services
UPDATED: 8/13/2015

General Information

- Providers will only track Ryan White service categories and sub-service categories for which they are funded under their current Ryan White Part B or D contract. Providers who want to track clients, service categories, and/or sub-service categories that are not funded by Ryan White will need to talk to MDHHS to set up non-Ryan White contracts in CAREWare.
- CAREWare data for the previous month is due by the tenth of each month. For example, CAREWare data for August must be logged into the system by September 10th.
- Decimals should not be used to record service units in CAREWare. Use whole units only.
- Where there is overlap in definitions for sub-service categories or multiple activities within the same timeframe, the best sub-service category should be used to describe the activity without counting activities twice. For example, if a medical case manager meets with a client for 15 minutes during which time he provides general support as well as a referral for counseling, this would be counted as 1 unit for MCM Referral.
- For early intervention services, medical case management, and non-medical case management, progress notes must correspond to the units of service entered in CAREWare.

Child Care Services: SUPPORT

- **HRSA Program Standard:** "Funding for Child Care Services for the children of HIV-positive clients, provided intermittently, only while the client attends medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions. May include use of funds to support: A licensed or registered child care provider to deliver intermittent care; Informal child care provided by a neighbor, family member, or other person (with the understanding that existing Federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services) Such allocations to be limited and carefully monitored to assure: • Compliance with The prohibition on direct payments to eligible individuals • Assurance that liability issues for the funding source are carefully weighed and addressed through the use of liability release forms designed to protect the client, provider, and the Ryan White Program."
- **Units Definition:** 1 unit = 1 childcare session
- **Definition of sub-service categories**:
    - Child Care Payment: activities related to providing financial assistance for client to access childcare service

Early Intervention Services: CORE

- **HRSA Program Standard**: "Support of Early Intervention Services that include identification of individuals at points of entry and access to services and provision of: HIV testing and targeted counseling, referral services, linkage to care, and health education and literacy training that enable clients to navigate the HIV system of care. All four components to be present, but Part A/B funds to be used for HIV testing only as necessary to supplement, not supplant, existing funding."
- **Units Definition**: 1 unit = 15 minutes of services provided
- **Definition of sub-service categories**:
    - EIS Health Education/Risk Reduction: activities related to improving knowledge and skills related to health education and literacy, HIV disease and related topics, accessing and maintaining medical care, medication adherence, risk reduction, case management and continuum of HIV care
    - EIS Referral: activities related to providing a referral of ANY type, advocating on client's behalf regarding referral, or following up with referral source or client on referral outcome
    - EIS General Support: activities that do not easily fit into other categories listed here; can include: listening to client, providing support, advocating on client's behalf, etc.
    - EIS Travel: activities related to an EIS worker travelling/transporting client to an appointment
    - EIS Linkage to Medical Care Confirmed: activities related to confirming that a client has attended a medical visit. Only one unit should be used for each event. Confirming medical visits should not be done by client self-report alone, but verified with a medical clinic/provider to guarantee attendance. This unit must be entered for the date that the client attended the medical appointment, not for the date the appointment was verified.
    - EIS Linkage to Services Confirmed: activities related to confirming that a client has been linked to any services other than medical care; while EIS Referral is used for all other activities related to referrals, this is only used when the client has actualized the referral.
    - EIS Discharge: activities related to terminating client's services; can include discussing discharge with client and paperwork related to discharge.

Emergency Financial Assistance: **SUPPORT**

- **HRSA Program Standard**: "Support for Emergency Financial Assistance for essential services including utilities, housing, and food (including groceries, food vouchers, and food stamps), or medications, provided to clients with limited frequency and for limited periods of time, through either: short-term payments to agencies or establishment of voucher programs. Direct cash payments to clients are not permitted."
- **Units Definition:** 1 unit = 1 occurrence of payment made
- **Definition of sub-service categories**:
    - EFA Heat/Gas: the activity of making a short-term payment for heat/gas utilities
    - EFA Electric: the activity of making a short-term payment for electric utilities
    - EFA Water: the activity of making a short-term payment for water utilities
    - EFA Medications: the activity of making a short-term payment for prescriptions/medications

- EFA Food: the activity of making a short-term payment for food
- EFA Housing: the activity of making a short-term payment for housing

Food Bank/Home Delivered Meals: SUPPORT

- **HRSA Program Standards:** "Funding for Food Bank/Home-delivered Meals that may include: the provision of actual food items; provision of hot meals; a voucher program to purchase food. May also include the provision of non-food items that are limited to: personal hygiene products; household cleaning supplies; water filtration/purification systems in communities where issues with water purity exist. Appropriate licensure/certification for food banks and home delivered meals where required under State or local regulations. No funds used for: permanent water filtration systems for water entering the house; household appliances; pet foods; other non-essential products."
- **Units Definition:** 1 unit = 1 occurrence of providing a food bank/voucher item
- **Definition of sub-service categories:**
  - FB Food Voucher: the activity of providing a food voucher to a client
  - FB Food Bank: the activity of providing a food bank item(s) to a client
  - FB Nutritional Supplements: the activity of providing nutritional supplements to a client.

Health Education/Risk Reduction: SUPPORT

- **HRSA Program Standard**: "Support for Health Education/Risk Reduction services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. Includes: provision of information about available medical and psychosocial support services; education on HIV transmission and how to reduce the risk of transmission; counseling on how to improve their health status and reduce the risk of HIV transmission to others."
- **Units Definition:** 1 unit = 1 session
- **Definition of sub-service categories**:
  - HERR: activities related to assessing and addressing client's risk reduction issues; the sub-service category only applies to providers that are funded for HERR as a service category; if a medical case management or outpatient and ambulatory medical care client receives HERR services, the sub-service category specific to that service category (i.e. MCM HERR or Medical Nursing HERR) and unit definition must be used."

Health Insurance Premium and Cost-Sharing Assistance (HIPCA): CORE

- **HRSA Program Standard:** "Provision of Health Insurance Premium and Cost-sharing Assistance that provides a cost-effective alternative to ADAP by: purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low income clients that provide a full range of HIV medications; paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of the client; providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs."
- **Units Definition:** 1 unit = 1 occurrence of payment made
- **Definition of sub-service categories**:

- Medical Payment Assistance: activities related to providing financial assistance for client to cover the costs related to medical visit co-pays (including co-pays for prescription eyewear for conditions related to HIV infection), co-insurances, and deductibles. This does not include financial assistance related to health insurance premiums, medication co-pays, emergency medications, mental health therapy, or outpatient substance abuse treatment. [**formerly captured under OAMC**]

Home and Community-Based Health Services: CORE

- **HRSA Program Standard:** "Provision of Home and Community-based Health Services, defined as skilled health services furnished in the home of an HIV-infected individual, based on a written plan of care prepared by a case management team that includes appropriate health care professionals. Allowable services to include: durable medical equipment; home health aide and personal care services; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostic testing; appropriate mental health, developmental, and rehabilitation services; specialty care and vaccinations for hepatitis con-infection, provided by public and private entities."
- **Units Definition:** 1 unit = 1 session
- **Definition of sub-service categories**:
  - HCB Care: activities related to providing skilled health services in client's home (activities that do not easily fit into other category listed here)
  - HCB Home Health Aide: services provided by a home health aide in client's home
  - HCB Occupational Therapy: activities related to provision of occupational therapy in client's home
  - HCB Physical Therapy: activities related to provision of providing physical therapy in client's home
  - HCB Registered Nurse: services provided by a registered nurse in client's home

Linguistics Services: SUPPORT

- **HRSA Program Standard:** "Support for Linguistic Services including interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of Ryan White-eligible services."
- **Units Definition:** 1 unit = 1 session
- **Definition of sub-service categories**:
  - Linguistics Interpreter Service: the activity of providing a session of interpreter service

Medical Case Management, including Treatment Adherence: CORE

- **HRSA Program Standard:** "Support of Medical Case Management (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals including both medically credentialed and other health care staff who are part of the

clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication. Activities that include at least the following: initial assessment of service needs; development of a comprehensive, individualized care plan; coordination of services required to implement the plan; continuous client monitoring to assess the efficacy of the plan; periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary. Service components that may include: a range of client-centered services that link clients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services); coordination and follow-up of medical treatments; ongoing assessment of the client's and other key family members' needs and personal support systems; treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments; client-specific advocacy and/or review of utilization of services."

- **Units Definition**: 1 unit = 15 minutes of service provided
- **Definition of sub-service categories**:
    - MCM Intake: activities related to initial rapport building, completing an intake form, gathering eligibility information, completing consents and releases (if applicable)
    - MCM Assessment: activities related to completing biopsychosocial assessment and acuity scale, completing consents and releases (if applicable)
    - MCM Service Plan Development: activities related to completing the service plan at assessment or reassessment; this must be done every 6 months at minimum
    - MCM General Support: activities that do not easily fit into other categories listed here; can include: listening to client, providing support, advocating on client's behalf, etc.
    - MCM Treatment Adherence: activities related to assessing and addressing medication adherence issues
    - MCM Reassessment: activities related to updating client's biopsychosocial areas and acuity scale, updating eligibility information, updating consents and releases (if applicable)
    - MCM Monitoring: activities related to monitoring client's service plan needs
    - MCM Discharge: activities related to terminating client's services; can include discussing discharge with client and paperwork related to discharge.
    - MCM HIV Specialist Confirmed: activities related to confirming that a client has attended a medical visit; Only one unit should be used for each event. Confirming medical visits should **not** be done by client self-report alone, but verified with a medical clinic/provider to guarantee attendance. This unit must be entered for the date that the client attended the medical appointment, not for the date the appointment was verified.
    - MCM Referral: activities related to providing a referral of ANY type, advocating on client's behalf regarding referral, following up with referral source or client on referral outcome, and confirming referral was actualized

- MCM Care Coordination: activities related to supervision, case conference, contact with client's providers related to coordinating client's service
- MCM Health Education/Risk Reduction: activities related to assessing and addressing client's risk reduction issues
- MCM Travel: activities related to a MCM travelling/transporting client to an appointment

Medical Nutrition Therapy including nutritional supplements: **CORE**

- **HRSA Program Standard:** "Support for Medical Nutrition Therapy services including nutritional supplements provided outside of a primary care visit by a licensed registered dietitian; may include food provided pursuant to a physician's recommendation and based on nutritional plan developed by a licensed registered dietitian."
- **Units Definition:** 1 unit = 1 session of medical nutrition therapy or 1 occurrence of medical nutritional supplement provided (regardless of the number of cans provided)
- **Definition of sub-service categories**:
  - MNT Medical Nutrition Services: the activity of providing a session of medical nutritional therapy by a dietitian
  - MNT Nutritional Supplement: the activity of providing a supply of medical nutritional supplement by a dietitian

Medical Transportation Services: **SUPPORT**

- **HRSA Program Standard**: "Funding for Medical Transportation Services that enable an eligible individual to access HIV-related health and support services, including services needed to maintain the client in HIV medical care, through either direct transportation services or vouchers or tokens. May be provided through: contracts with providers of transportation services voucher or token systems, use of volunteer drivers (through programs with insurance and other liability issues specifically addressed), purchase or lease of organizational vehicles for client transportation programs, provided the grantee receives prior approval for the purchase of a vehicle."
- **Units Definition:** 1 unit = 1 occurrence of providing transportation *(This can include: 1 bus ticket, OR one-way trips in vans or cabs, OR one-way rides provided by a contracted driver, OR 1 gas card.)*
- **Definition of sub-service categories**:
  - Trans Bus ticket: the activity of providing a bus ticket to a client
  - Trans Van: activities related to arranging and paying for handicap-accessible van services
  - Trans Cab: activities related to arranging and paying for cab services
  - Trans Driver**:** activities related to providing transportation
  - Trans Gas card: the activity of providing a gas card to a client

Mental Health Services: **CORE**

- **HRSA Program Standard**: "Funding for Mental Health Services that include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or

authorized within the State to provide such services typically including psychiatrists, psychologists, and licensed clinical social workers."

- **Units Definition:** 1 unit = 15 minutes of service or 1 occurrence of payment made
- **Definition of sub-service categories**:
    - MH Assessment: activities related to completing a mental health assessment
    - MH Treatment Plan: activities related to completing a treatment plan
    - MH Individual: activities related to providing one individual session
    - MH Group: activities related to providing one group session
    - MH Family: activities related to providing one family session
    - MH Psychiatric Consultation: activities related to a psychiatrist completing a medical assessment
    - MH Medication Evaluation: activities related to a psychiatrist completing a medication update or follow-up
    - MH Discharge: activities related to terminating client's services; can include discussing discharge with client and paperwork related to discharge.
    - MH Payment Assistance: activities related to providing financial assistance for client to access mental health therapy

Non-medical Case Management: **SUPPORT**

- **HRSA Program Standards**: "Support for Case Management (Non-medical) services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial and other needed services. May include: benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible; all types of case management encounters and communications (face-to-face, telephone contact, other); transitional case management for incarcerated persons as they prepare to exit the correctional system. Does not involve coordination and follow-up of medical treatments."
- **Units Definition**: 1 unit = 15 minutes of service provided
- **Definition of sub-service categories**:
    - NMCM Screening: activities related to initial rapport building, completing an intake form, gathering eligibility information, completing consents and releases (if applicable);
    - NMCM Referral: activities related to providing a referral of ANY type, advocating on client's behalf regarding referral, following up with referral source or client on referral outcome, and confirming referral was actualized
    - NMCM General Support: activities that do not easily fit into other categories listed here; can include: listening to client, providing support, advocating for client, etc.
    - NMCM Discharge: activities related to terminating client's services; can include discussing discharge with client, paperwork related to discharge.

Outpatient/Ambulatory Health Services: **CORE**

- **HRSA Program Standards**: "Provision of Outpatient and Ambulatory Medical Care, defined as the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with Public Health Services (PHS) guidelines and

including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Allowable services include: diagnostic testing; early intervention and risk assessment; preventive care and screening; practitioner examination; medical history taking; diagnosis and treatment of common physical and mental conditions; prescribing and managing of medication therapy; education and counseling on health issues; well-baby care; continuing care and management of chronic conditions; referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services)."

"As part of outpatient and ambulatory medical care, provision of laboratory tests integral to the treatment of HIV infections and related complications"

- **Units Definition**: 1 unit = 1 occurrence of the specified activity
- **Definition of sub-service categories**:
    - Medical New Routine: activities related to the evaluation and management of a new patient, which requires a detailed history and physical examination, and medical decision-making of *low acuity*
    - Medical New Complex: activities related to the evaluation and management of a new patient, which requires a detailed history and physical examination, and medical decision-making of *moderate to high acuity*
    - Medical Return Routine: activities related to the evaluation and management of an established patient, which requires addressing any medical changes since last visit that may require follow up, and/or medical decision-making of *low acuity*
    - Medical Return Complex: activities related to the evaluation and management of an established patient, which requires addressing any medical changes since last visit that may require follow up, and/or medical decision-making of *moderate to high acuity*
    - Medical Follow Up: activities related to clinical staff providing follow up from a clinical visit, such as abnormal labs, physician orders, physician referrals, medication changes, or any direct clinical staff orders
    - Medical Treatment Adherence: activities related to assessing and addressing medication adherence issues provided in the medical setting
    - Medical Nursing Assessment: comprehensive nursing assessment that includes but is not limited to: base vital signs, pain assessment, respiratory assessment, gastrointestinal assessment, neurological checks, medical history, and medication reconciliation
    - Medical Nursing Health Education/ Risk Reduction: general overall health education provided to the client which may address: smoking cessation, diabetes, obesity, hypertension, hepatitis, age-appropriate health screens (such as paps, mammograms, cholesterol, etc), medication regimens, vaccination, gastrointestinal issues, hygiene, or any other education regarding the prevention and/or management of chronic disease care
    - Medical Nursing Care Coordination: nursing activities that provide for the exchange of nursing and medical client information that is shared with the interdisciplinary HIV care team related to coordinating the client's services

Outreach Services: (MAI funds only) SUPPORT

- **HRSA Program Standard:** "Support for Outreach Services designed to identify individuals who do not know their HIV status and/or individuals who know their status and are not in care and help them to learn their status and enter care. Outreach programs must be: planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; targeted to population known through local epidemiologic data to be at disproportionate risk for HIV infection; targeted to communities or local establishments that are frequented by individuals exhibiting high-risk behavior; conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; designed to provide quantified program reporting of activities and results to accommodate local evaluation of effectiveness. Funds may not be used to pay for HIV counseling and testing. "
- **Units Definition:** 1 unit = 15 minutes of service
- **Definition of sub-service categories**:
  - MDOC Outreach: all activities related to connecting an incarcerated individual to community case management upon release and following up that linkage has occurred
  - MDOC Medication Access Confirmed: activities related to confirming that a client recently released from incarceration has access to medications

Pediatric Developmental Assessment: (Part D service only) SUPPORT

- **HRSA Program Standard:** "Pediatric Developmental Assessment is the provision of professional, early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant or a child's developmental status and needs in relation **to the education system, including early assessment of educational intervention services. They** include comprehensive assessment, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools also should be reported in this category."
- **Units Definition:** 1 unit = 15 minutes of service
- **Definition of sub-service categories**:
  - Developmental Assessment: activities related to completing a pediatric developmental assessment

Psychosocial Support Services: SUPPORT

- **HRSA Program Standard: "**Support for Psychosocial Support Services that may include: support and counseling activities; child abuse and neglect counseling; HIV support groups; pastoral care/counseling; caregiver support; bereavement counseling; nutrition counseling provided by a non-registered dietitian. Funds under this service category may not be used to provide nutritional supplements. Pastoral care/counseling supported under this service category to be: provided by an institutional pastoral care program (e.g. components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as home care or hospice provider); provided by a licensed or accredited provider

wherever such licensure or accreditation is either required or available; available to all individuals eligible to receive Ryan White services, regardless of their religious denominational affiliation."

- **Units Definition:** 1 unit = 1 session
- **Definition of sub-service categories**:
    - PSS Group Support: the activity of providing psychosocial support in a group setting

Rehabilitation Services: **SUPPORT**

- **HRSA Program Standard:** "Funding for Rehabilitation Services: Services intended to improve or maintain a client's quality of life and optimal capacity for self-care, provided by a licensed or authorized professional in an outpatient setting in accordance with an individualized plan of care. May include: physical and occupational therapy; speech pathology services; low-vision training."
- **Units Definition**: 1 unit = 1 session
- **Definitions of sub-service categories:**
    - Rehabilitation Service: the activity of providing a session of rehabilitative services

Substance Abuse Treatment Services-Outpatient: **SUPPORT**

- **HRSA Program Standard:** "Support for Substance Abuse Treatment Services-Outpatient, provided by or under the supervisor of a physician or other qualified/licensed personnel; may include use of funds to expand HIV-specific capacity programs if timely access to treatment and counseling is not otherwise available. Services limited to the following: pre-treatment/recovery readiness programs; harm reduction; mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse; outpatient drug-free treatment and counseling; opiate assisted therapy; euro-psychiatric pharmaceuticals; relapse prevention; limited acupuncture services with a written referral from the client's primary health care provider, provided by certified or licensed practitioners wherever State certification or licensure exists; services provided must include a treatment plan that calls only for allowable activities and includes: the quantity, frequency, and modality of treatment provided; the date treatment begins and ends; regular monitoring and assessment of client progress; the signature of the individual providing the service and/or the supervisor as applicable."
- **Units Definition**: 1 unit = 1 occurrence of payment made
- **Definition of sub-service categories:**
    - SA Payment Assistance: activities related to providing financial assistance for client to access outpatient substance abuse treatment

Treatment Adherence Counseling: **SUPPORT**

- **HRSA Program Standard:** "Support for Treatment Adherence Counseling, which is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments, provided by non-medical personnel outside of the Medical Case Management and clinical setting."
- **Units Definition:** 1 unit = 1 session
- **Definition of sub-service categories**:

- Treatment Adherence: activities related to assessing and addressing medication adherence issues; the sub-service category only applies to providers that are funded for treatment adherence counseling as a service category; if a medical case management or outpatient and ambulatory medical care client receives treatment adherence counseling services, the sub-service category specific to that service category (i.e. MCM Treatment Adherence or Medical Treatment Adherence) and unit definition must be used

Note: Suggestions for edits to this document will be accepted on an ongoing basis. Updates will be made once per year. To suggest edits, please contact Program or QM staff: 517-241-5900

References

For more information on the HRSA Program Standards mentioned above, please access the following documents:

HIV/AIDS Bureau, Division of State HIV/AIDS Programs National Monitoring Standards for Ryan White Part B Grantees: Program—Part B at http://hab.hrsa.gov/manageyourgrant/files/programmonitoringpartb.pdf

Health Resources and Services Administration, HIV /AIDS Bureau Policy Notice 10-02 Eligible Individuals and Allowable Uses of Funds for Discretely Defined Categories of Services at http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html

Appendix B

MDHHS Summary of Performance Measures – Part B

Service Category	CW Label	Measure	Numerator	Denominator	Relevant Data Elements
Med CM Outpt./Ambulatory	1BMCM 1BO/A	HIV VIRAL LOAD SUPPRESSION 1. Percentage of patients, regardless of age, with a diagnosis of HIV with a viral load less than 200 copies/mL at last HIV viral load test during the measurement year	Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit, at least one Part B service, and at least one specified service [see CW Label] in the measurement year	Last Quantitative Lab Value HIV Positive Any Outpatient/Ambulatory Visit -OR- MCM HIV Specialist Confirmed -OR- EIS Linkage to Medical Care Confirmed
EIS Med CM Outpt./Ambulatory	2BEIS 2BMCM 2BO/A	PRESCRIPTION OF HIV ART 2. Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit, at least one Part D service, and at least one specified service [see CW Label] in the measurement year	# of ARV active ingredients HIV Positive Any Outpatient/Ambulatory Visit -OR- MCM HIV Specialist Confirmed -OR- EIS Linkage to Medical Care Confirmed
EIS Emerg Finan Assist. Foodbank HERR HealthInsPremHIPCA Housing Linguistic Med CM Med Nutr. Therapy Med Transport Mental Health Non Med CM Outpt./Ambulatory Psychosocial Supp Subst. Abuse Treatment Adher	4BEIS 4BEFA 4BFB 4BHERR 4BHPCA 4BH 4BL 4BMCM 4BMNT 4BMT 4BMH 4BNMCM 4BO/A 4BPS 4BSA:O 4BTAC	GAP IN HIV MEDICAL VISITS 4. Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year	Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year	Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year, and at least one Part D service, and at least one specified service [see CW Label] in the measurement year *EXCLUDES clients that died during measurement year	HIV Positive Any Outpatient/Ambulatory Visit -OR- MCM HIV Specialist Confirmed -OR- EIS Linkage to Medical Care Confirmed Vital Status

MDHHS Summary of Performance Measures – Part D

Service Category	CW Label	Measure	Numerator	Denominator	Relevant Data Elements
Med CM Outpt./Ambulatory	1DMCM 1DO/A	HIV VIRAL LOAD SUPPRESSION 1. Percentage of patients, regardless of age, with a diagnosis of HIV with a viral load less than 200 copies/mL at last HIV viral load test during the measurement year	Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit, at least one Part D service, and at least one specified service [see CW Label] in the measurement year	Last Quantitative Lab Value HIV Positive Any Outpatient/Ambulatory Visit -OR- MCM HIV Specialist Confirmed -OR- EIS Linkage to Medical Care Confirmed
Med CM Outpt./Ambulatory	2DMCM 2DO/A	PRESCRIPTION OF HIV ART 2. Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit, at least one Part D service, and at least one specified service [see CW Label] in the measurement year	# of ARV active ingredients HIV Positive Any Outpatient/Ambulatory Visit -OR- MCM HIV Specialist Confirmed -OR- EIS Linkage to Medical Care Confirmed
HERR Linguistic Med CM Med Nutr. Therapy Med Transport Mental Health Non Med CM Outpt./Ambulatory Psychosocial Supp Treatment Adher	4DHERR 4DL 4DMCM 4DMNT 4DMT 4DMH 4DNMCM 4DO/A 4DPS 4DTAC	GAP IN HIV MEDICAL VISITS 4. Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year	Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year	Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year, and at least one Part D service, and at least one specified service [see CW Label] in the measurement year *EXCLUDES clients that died during measurement year	HIV Positive Any Outpatient/Ambulatory Visit -OR- MCM HIV Specialist Confirmed -OR- EIS Linkage to Medical Care Confirmed Vital Status

For reference of all D and B performance measures, visit HRSA HAB Performance Measures at http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html